TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
OAKBEND MEDICAL CENTER

MFDR Tracking Number
M4-18-0236-01

MFDR Date Received
September 27, 2017

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the hospital received authorization in an August 30, 2016 letter from Texas Mutual, authorizing ten (10) sessions of physical therapy. After being provided with these authorized sessions, the Hospital medical staff determined that additional physical therapy was necessary and provided it on the above dates of service. The Hospital billed Texas Mutual, and the only item on the bill that was paid was for the re-evaluation on October 24, 2016. The remainder of the bill was denied because additional authorization was not obtained."

Amount in Dispute: $ 8,292.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization was required for the additional therapy... No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
October 3, 2016 through October 24, 2016	REV Code 0420 and 0424 (physical therapy services)	$8,292.72	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-197- Precertification/authorization/notification absent.
   - Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service.
   - 930 – Pre-authorization required, reimbursement denied

Issues

1. Did the requestor obtain preauthorization for the disputed physical therapy services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for physical therapy services rendered on October 3, 2016 through October 24, 2016. The insurance carrier states in pertinent part, "Preauthorization was required for the additional therapy." The requestor states in pertinent part, "The remainder of the bill was denied because additional authorization was not obtained."

   The insurance carrier denied the disputed services with denial reduction code "CAC-197- Precertification/ authorization/ notification absent" and "Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service" and "930 – Pre-authorization required, reimbursement denied."

   28 Texas Administrative Code §134.600(p) (5) states in pertinent part, "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning..."

   Review of the submitted documentation finds the following:

   The requestor obtained preauthorization for physical therapy services to be rendered between 8/30/16-09/30/16, authorization issued on August 30, 2016 by Texas Mutual Workers' Compensation Insurance, authorization # 12305479.

   The requestor made a preauthorization request for additional physical therapy services on October 26, 2016. Texas Mutual Workers' Compensation Insurance denied the request for additional physical therapy services on October 31, 2016.

   The Division finds that the disputed physical therapy services required preauthorization. The requestor submitted insufficient documentation to support that preauthorization was obtained. As a result, reimbursement is not recommended for dates of service October 3, 2016 through October 24, 2016.

2. Review of the submitted documentation finds that preauthorization was required for the disputed physical therapy services. The requestor submitted insufficient documentation to support that preauthorization was obtained for the disputed services. As a result, reimbursement for the disputed physical therapy services cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 10, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.